TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GRAPEVINE SURGICARE PARTNERS

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-17-3070-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JUNE 19, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2016 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $1,705.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It was determined that no additional payment is owed to provider."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2016	Ambulatory Surgical Care Services for CPT Code 29888-RT	$0.00	$0.00
	Ambulatory Surgical Care Services for CPT Code 29881-RT	$0.00	$0.00
	HCPCS Code L8699	$1,239.70	$0.00
	HCPCS Code L8699	$534.30	$0.00
TOTAL		$1,705.29	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.10 sets out the general medical billing procedures.
3. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

    - 148-This procedure on this date was previously reviewed.
    - 131-Claim specific negotiated discount.
    - 18-Duplicate claim/service.
    - ES104-Charges for surgical implants will be reviewed separately by ForeSight Medical.
    - Device payment was based on documentation provided by your facility.

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?

2. What is the recommended payment for the services in dispute? Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of $1,705.29 for HCPCS code L8699, rendered to the claimant on December 8, 2016.

    The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

2. 28 Texas Administrative Code §134.402(d) states,

    > For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

    HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified."

    To determine if the requestor was appropriately reimbursed, the division refers to 28 Texas Administrative Code §134.402(f)(2)(B)(i).

    28 Texas Administrative Code §134.402(f)(2)(B)(i) states, "The reimbursement calculation used for establishing the MAR shall be…(B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

    The Division reviewed the submitted documentation and finds that the requestor did not submit the manufacturer's invoices for the implantables to support cost. As a result, additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		7/26/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.